An introduction to co-morbidity
(co-occurring mental health and alcohol and other drug problems)

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Overview

- Common definitions
- Prevalence
- Common co-morbidities
- Impacts
- Models of care
- Principles of treatment
- Summary
Common definitions

- Co-morbidity
- Dual Diagnosis
- Co-occurring disorders

Alcohol and or other drug use disorder with any mental health disorder according to diagnostic classification system.

Also includes symptoms of a disorder which may not meet diagnostic criteria.

(NDARC 2010)
Prevalence

From your clinical experience:

- How common is it for AOD clients to present with co-occurring mental health issues?
- How common is it for MH clients to present with co-occurring AOD issues?
Prevalence continued

- Australian National Survey of Mental Health and Wellbeing (2007):
  - 1 in 5 Australian adults had anxiety, mood or substance use disorder in the past year
  - 35% of individuals with a substance use disorder (31% of men and 44% of women) have at least one co-occurring affective or anxiety disorder
Prevalence continued

- Within AOD treatment populations
  - Mental disorders range from 51 – 84% (Brems and Johnson 1997, cited in NDARC 2010)
  - Most common are mood, anxiety and personality disorder
  - Rates of trauma exposure and Post Traumatic Stress Disorder (PTSD) are high
  - Increase in psychosis with increasing use of methamphetamine
Common co-morbidities

- Tobacco and mental health disorder
- Alcohol and depression and or anxiety
- Amphetamines and psychosis
- Cannabis and psychosis
- Personality disorder and substance use disorder
Impacts of Co-morbidity

Alcohol & Other Drug Problems

- Accommodation problems
- Increased criminal activity
- Poorer physical health & self-care
- Unemployment

Mental Health Problems

- Relationship Problems & Isolation
- Fewer social supports
- Increased relapse rates
- Increased hospital admissions

Co-morbidity

- Increased Suicide Rates
- Increased rates of Self harm
- Higher rates of HIV & HCV Infection
- Worse psychiatric symptomology & treatment compliance

Queensland Health, Dual Diagnosis Strategic plan (2003)
Impacts for family and or significant others

- High stress – requires resilience and healthy coping skills
- Puts strain on family members and family functioning
- Financially costly
- Feeling unsupported and stigmatised
- A full time job
Impact on treatment agencies

- More complex presentations
- Treatment can be more labour intensive
- Worse psychiatric symptomology
- Frequent AOD relapse
- Poorer treatment compliance and recovery
- Greater treatment and service resources
- Staff feel unskilled and lack confidence
- Limited time and resources
Impacts for the community

- Social disruption
- Increased homelessness
- Higher rates of criminal activity
- Higher rates of incarceration
- Increased rates of intravenous drug use and subsequent BBV rates
- Increased costs to treat – higher rates of admissions and readmissions
- Feel threatened and fearful
Models of care

3 models of care have been identified:

- Sequential
- Parallel
- Integrated
Models of care continued

- Sequential model of care
  - Treat one problem first, then the other
  - Clients are not eligible for treatment in one service until the other primary problem is resolved or stabilised
  - Clients are often bounced between services
  - Has lead to clients being excluded from services
  - Risk of clients falling through gaps and not receiving care
Models of care continued

• Parallel treatment
  • Both problems are treated concurrently by two separate treatment services
  • Client has to navigate attending 2 separate services with different case managers, philosophies, models of care, etc
  • Risk of client falling through the gap and receiving no care
  • Can work with good co-case management between services
Models of care continued

• Integrated care
  • Provision of treatment for both problems by a single clinician or team
  • If this is not possible than through a formal collaboration process provided by both services where the service seems seamless to the client
  • Literature supports this model particularly for people with serious mental health problems
    (Kavanagh & Mueser 2007)
Models of care continued

Growing body of evidence suggests individuals with severe mental health problems and co-occurring substance use do best under an integrated model (Kavanagh & Mueser 2007).
The quadrant model:

- Increased international focus on the need for collaboration between service sectors
- Quadrant model is a conceptual framework (Minkoff 2003)
- Provides guidance for the level of service coordination
- Used to inform service sector responsibility
- Defines disorders in terms of symptom severity rather than diagnosis
Quadrant Model

Quadrant III
More severe mental disorder, less severe alcohol and other drug use

Quadrant IV
More severe mental disorder, more severe alcohol and other drug use
Co-case management with ADS – primary responsibility MHS

Quadrant I
Less severe mental disorder, less severe alcohol and other drug use
Primary Care and or Community AOD

Quadrant II
Less severe mental disorder, more severe alcohol and other drug use
AOD sectors

US Department of Health & Human Service, Substance Abuse and Mental health Services Administration (2003). Strategies for Developing Treatment Programs for People with Co-occurring Alcohol and Other Drug Use and Mental Disorder. SAMHSA, USA
Model of care continued

The Quadrant Model:

‘It is critical that the application of this framework is flexible and adaptable to individual circumstance and not applied to exclude clients from services’

Queensland Health dual diagnosis clinical guidelines (2010)
Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems)

Released September 2008
Policy statement

‘People with DD and their families have multiple and complex care needs that require a high level response from ATODS and MHS, across all levels of care and recovery including engagement, screening, assessment, treatment, rehabilitation, discharge planning and aftercare’.
Models of care continued

- Specialist consultation between mental health and alcohol and other drug services can include:
  - Joint assessments
  - Joint case conferencing
  - Supervision
  - Joint training
  - Consultation and liaison
Principles of treatment

- **Collaborative partnerships** between MH, AOD sector, and with professionals in primary care, social services, housing, criminal justice, education and related fields. This includes services across government, non-government and the private sectors.
Principals of treatment continued

- **Expectation not the exception**
  - System planning, service operations and the delivery of treatment and care needs to acknowledge this.

- **Integrated model of care**
  - This approach ensures continuity, quality and a seamless approach to service delivery across a variety of agencies.

- **No wrong door approach**
  - ‘Every door is the right door’ to care either by direct service provision or linkage to appropriate agency as opposed to sending a person from one agency to another.
Principals of treatment continued

- **Therapeutic alliance**
  - Effective treatment is based on the establishment of a quality relationship based on mutual respect, empathy and hope

- **Bio-psychosocial approach**
  - Comprises an array of physical, psychological, and social interventions

- **Harm minimisation approach**
  - AOD treatment goals need to be realistic and achievable can range from the reduction of harms to abstinence and interventions

- **Recovery based approach**
  - With effective linkage with the broader social service network to meet the complex needs of people with co-morbidity
Principals of treatment continued

- Both problems are considered of primary importance to the clinical presentation
  - Given equal priority in treatment and be continually assessed and managed
- Special populations
  - Including youth, aboriginal people, culturally and linguistically diverse populations, women and older people
- Active participation of the person, primary carers, family or significant others
  - In the treatment, care and recovery
- Contribution of the community
  - To the course of recovery and the contribution people with co-morbidity back to the community acknowledged
Co-occurring disorders are the expectation not the exception
Impacts are very significant
Integrated care is the gold standard for people with serious mental health problems
Collaborative integration amongst key stakeholder is necessary
Service policies, procedures and protocols are required to direct practice
Sustainable workforce initiatives are vital
References

Australian Bureau of Statistics. 2007. *National Survey of Mental Health and Wellbeing: summary of results 4326.0*


US Department of Health & Human Service, Substance Abuse and Mental health Services Administration. 2003. *Strategies for Developing Treatment Programs for People with Co-occurring Alcohol and Other Drug Use and Mental Disorder*. SAMHSA, USA
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